MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

January 13, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, January 13, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Doug Berger, Charlie Dannelly, James Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Advisory member Representative Van Braxton was also present.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson and Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. Representative Insko informed attendees that the tours to Dix Hospital and Central Regional were cancelled due to logistical problems, but encouraged members to tour the facilities on their own. She advised that public comments would be heard on the two facilities during the meeting. She asked for a motion to approve the minutes from the December 9, 2009 meeting. The motion was made by Senator William Purcell and the minutes were approved.

Dr. Barry Boardman from the Fiscal Research Division provided an overview of revenue projections. He noted that collections were behind expectations for the month of November - $110M short of the budget target. The shortfall through December was eliminated due to a one-time collection of $422M ($272M more than budgeted) through the Department of Revenue working with corporate taxpayers. Problems with revenue now are economy based – sales tax collection, and wage withholding, caused by a weak economy. He said withholding represents 40% of the General Fund and that is 4% below last year. Sales tax represents 25% - 28% of the General Fund collection and that is running 12% below last year. Absent the $272M, the shortfall should be about 2.6%. Dr. Boardman projected the remainder of the fiscal year looked bleak primarily due to the unemployment situation.

Dr. Boardman was asked how much money North Carolina owed the federal government to pay back funds borrowed for unemployment and if interest was accruing. He responded that he would get that information. Senator Nesbitt clarified that it was a federal program that actually owed a trust fund debt, and not a debt of the State. He was

also asked to address the new "baseline" for the continuation budget after the Governor's 5% hold-back. Lisa Hollowell from Fiscal Research responded that the 5% withholding by the Governor was a one-time/non-recurring fix, anticipating a revenue or budget shortfall. These reductions are not recurring and when the budget is put together for next year the General Assembly will have the option of making some of these reductions permanent. Much like this year's budget, the General Assembly also took some of the Governor's reductions she made in last year's budget.

Lee Dixon from Fiscal Research provided an update on the Medicaid budget shortfall. He said that Medicaid enrollment was contributing to the shortfall. He said projections indicated that there would be an additional 18,000 enrollees by the end of this fiscal year. The increase is the cause of $85M of the shortfall. Utilization is also contributing to the shortfall. Mr. Dixon said the Medicaid budget in 2009 was based on a utilization of .25%. Utilization was up 4% across the board through November. This increase contributes an additional $90M towards the shortfall. There were also some planned budget reductions made be the General Assembly which required DHHS to submit State Plan Amendments to the Centers for Medicaid and Medicare Services (CMS). DHHS cannot implement the budget cuts until CMS approves the amendments. Community Care of North Carolina (CCNC) manages the utilization of services across the Medicaid population. In the last 14 months CCNC has undertaken managing services for the aged and disabled. Because the proper infrastructure is not in place, CCNC is not able to realize the $70M savings called for the budget. Mr. Dixon said that since September DHHS had been working to develop better management tools to determine what is happening across the Medicaid budget.

Representative Insko reminded members that at the last LOC meeting, members requested to hear comments from psychiatrists and psychologists concerning -CABHAs. First, Dr. April Harris-Britt, a licensed psychologist, presented her concerns on the potential impact of the CABHA model on mental health services. (See Attachment No. 2) Points of interest in her presentation included:

- Most controversial aspect of the CABHA model is the mandate of a medical director and the cost of this position. Fiscal feasibility of this requirement is questionable and it is uncertain whether it will achieve the desired clinical oversight.
- Current model anticipates having only 40-60 CABHA agencies statewide which would severely limit client and consumer choice.
- Goal should be to improve rather than eliminate existing services.
- In the end, the anticipated savings by these changes will eventually be channeled to support other issues and outcomes typically associated with untreated mental health problems.

Dr. John Gilmore, from the Department of Psychiatry at UNC, provided his opinion on the CABHA model from the perspective of a psychiatrist. His presentation included the following points of interest:

- North Carolina Psychiatric Association and those at the Department of Psychiatry at UNC strongly support the intent of CABHA to restore clinical integrity to the public mental health system.

- Current system is fragmented, wasteful, and often fails to provide the treatments proven to work.
- The cornerstones of effective treatment are a good diagnostic assessment, and evidence-based treatment provided by an integrated team of professionals; CABHAs are a definite step in that direction.
- There needs to be a transparent business model which ensures that good small providers are not put out of business.
- Fragmentation of the system has driven many professionals away; the CABHAs model will create a strong and stable provider network to correct that deficiency.

Members questioned DHHS about how new professionals could enter the system and provide the array of services offered within the CABHA model if CABHA certification requires three years of accreditation. Michael Watson, Assistant Secretary for DMH/DD/SAS Development, responded that people would enter the system and become accredited with non-CABHA services and then have an opportunity to become nationally accredited in order to move into CABHA services. Mr. Watson advised that the Department has received 250 applications from providers seeking CABHA certification. Members requested specific information on the number of small providers represented in the 250 applicants. Members expressed concern for small providers and the clients depending upon these services, and questioned whether the CABHA model should be a pilot.

Michael Watson addressed the initiatives from DHHS regarding MH/DD/SAS over the next one to two years. (See Attachment No. 3) He said the Department has a set of significant initiatives to reshape and define the service system at the community level, many of which are driven by instructions from the General Assembly. Points of interest included:

- Audit of the quality of services showed that 35% to 40% of services were (i) not medically necessary, (ii) poorly documented making it difficult to determine if and how the services were delivered or how they were delivered, (iii) delivered to people who did not need the services, or (iv) in some cases, false information was sent to Value Options as part of the authorization process.
- Services delivered by CABHAs include: Day Treatment, Intensive In-Home Therapy, Community Support Team, Case Management, and Peer Support.
- A technical amendment has been submitted to CMS that takes the Piedmont 1915(b) waiver and makes it a North Carolina waiver allowing DHHS to add 1-2 LMEs to the waiver in January 2011. CABHA initiative restructures the provider network to mirror what is required under a waiver environment.
- Mental Health Initiatives –Providers need to have capacity to deal with their own consumers in the community before going to an emergency room. DHHS is meeting with the Sheriff's Association and the Hospital Association regularly regarding capacity issues – how people are processed, how beds are found, and how assessments are made.
- Community Support Teams is close to becoming a $250M a year service; it has grown over the last 18 months from 1,000 people to 6,000 people receiving service.

Mr. Watson was questioned about the effect CABHA would have on clubhouses. He responded that clubhouse services do not require the provider to be a part of a CABHA. However, he added that clubhouses would be impacted if they were providing Community Support since they would not be able to deliver Case Management services. Mr. Watson said DHHS was looking at the workload of the clubhouses and considering a shorter Person Centered Plan. He added that they were also considering changing from daily notes to weekly notes in order to reduce paperwork for providers.

When questioned about how smaller providers could become CABHAs, Mr. Watson said many would either be acquired by larger providers or merge. The Department agreed to answers questions and offer guidance regarding mergers and corporate structure. Mr. Watson responded to members' questions regarding how CABHAs would be monitored by explaining that the LMEs would go on-site investigating complaints, reviewing records, and the LMEs and DHHS would have access to paid claims data for State funded services and Medicaid.

Representative Insko explained that, in anticipation of the site visits to the State institutions, the LOC had requested comments from interested parties. She recognized Larson Taylor with UE local 150, NC Public Service Workers Union. (See Attachment No. 4) Ms. Taylor's concerns addressed the Zero Tolerance policy implemented by DHHS in January, 2009. She expressed the frustration of all concerned that there is not a voice for the frontline workers. Rebecca Hart commented that the policy enabled patients to act as they wished and that staff was afraid of losing their jobs if patients were not handled exactly as the strict guidelines require.

After lunch, Michael Watson provided an update and answered questions from the December meeting and other questions from staff and the Committee on CABHA. (See Attachment No. 5) Points of interest included:

- The purpose of the CABHA is to ensure that mental health and substance abuse is delivered within a clinically sound framework, with economy of scale and efficiency.
- CABHAs seek to address clinical fragmentation by reducing stand alone service providers by having services delivered as part of a more comprehensive provider organization.
- With approval from CMS, CABHA will be funded by Case Management Case Rate which would pay providers per month for Case Management services.
- Two thirds of the 230 providers indicating interest in becoming a CABHA have met the requirements or will be able to meet the requirements.

Shawn Parker from the Research Division provided an introduction for the First Commitment Pilot item on the agenda. Mr. Parker provided the details for the process for inpatient involuntary commitment and provided a narrative of the legislation enacting the pilot program in 2003. The Appropriations Act of 2006 extended the pilot by 1 year. In the fall of 2006, DHHS presented a report to the LOC on the pilot in which the committee recommended that the pilot be made permanent and extended statewide. The LOC made

the recommendation and the General Assembly enacted in SL 2007-504 a three year extension and authorized up to five more LMEs to become pilots. This session the Secretary was authorized in SL 2009-340 to expand the program to 15 LMEs but absent further legislative action the program will sunset October 1, 2010.

Mr. Mark O'Donnell, LME Liaison and Project Director for the 1st Evaluation Pilot Project, DMH, together with Dr. Nidu Menon, Director of Evaluation of the Health Wellness Trust Fund, provided an update on the program. (See Attachment No. 6) Points of interest during their presentation included:

- In 2007, 32 counties across the State did not have registered psychiatrists; 26 counties did not have a psychologist. Numbers were also low for licensed clinical social workers and licensed clinical addictions specialists.
- Evaluation results showed a very high degree of correlation in decisions made between 3 groups of reviewers.
- Recommendation that waiver be continued and expanded statewide, since the pilot project indicates that licensed clinical social workers and licensed clinical addictions specialists who are properly trained, tested and certified, would make decisions similar to those made by psychologists, physicians, and psychiatrists.

Representative Insko stated that the recommendation would appear in the LOC report for consideration by the Committee to the General Assembly.

Representative Insko then recognized members of the audience, who had signed up previously, to come forward for the public comment period. Concerns expressed by the audience included:

- Professional Association Council - Support for DHHS in efforts to restore clinical integrity to the public mental health system to the philosophy outlined in the CABHA, recommendation to implement: clinical supervision, strengthen service definitions, confidence based system, valuing outpatient care, adequate rates and compensation, and workforce development.
- Support for NC Clubhouse Coalition – Model of best practice used and recognized in over 27 countries; 8 clubhouses average 20 years of service to N.C.; 90% success rate in avoiding rehospitalization; CABHAs will drive out small providers; ICCD Clubhouse program needs to build case management and continue Community Support Team without CABHA requirements; need a sustainable way for Clubhouse PSR programming; need simplified Person Centered Plan and return to monthly notes.
- Club Nova – N.C General Assembly needs to create and fund a model law that upholds the Umstead decision, the ADA and the basic civil rights of our citizens living with mental illness.
- The Coalition – Would like to be on LOC agenda to share information regarding cuts to services; ask that LOC work with other General Assembly members to make MHDDSAS a priority in the budget and in funding.
- N.C. Quality Care Provider Association – Need to slow down, system cannot handle the implementation of CABHA; infrastructure is not in place; rural areas struggling, difficult to find psychiatrists to work with adults and children;

mandated that if physician is serving as medical director they must be ASAM certified which further reduces the pool of available talent; create a phase in approach – work on coordination, share information, move to collaboration, then integration of services continuum of care.

- N.C. Psychiatric Association – Psychiatrists have concern regarding the Involuntary Commitment Pilot project and evaluation - safety of undiagnosed medical illnesses that present with psychiatric symptoms. When unrecognized and not treated promptly and appropriately, results can be catastrophic.

There being no further business, the meeting adjourned at 3:10 PM.

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Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant